TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM
(SCHIP)

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (CHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM
(SCHIP)

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: State of Washington
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

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(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Robin Arnold-Williams	Position/Title: Secretary/Department of Social and Health Services
Name: Doug Porter	Position/Title: Assistant Secretary/Health and Recovery Services Administration
Name: Kathy Johansen	Position/Title: Program Manager/State Children's Health Insurance Program

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ☒ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. ☐ A combination of both of the above.

Washington's CHIP offers comprehensive health coverage to children through age 18, who reside in households with incomes between 200% and 250% of the federal poverty level (FPL). CHIP is a non-entitlement program, with coverage offered within available state funds appropriated by Washington's legislature. Families are required to pay a modest premium for coverage. CHIP benefits are the same as the state's Medicaid program for children. The program utilizes the state's Medicaid managed care delivery system and employs Medicaid income eligibility criteria. However, the CHIP eligibility process is different due to restrictions about existing insurance. CHIP is administered by DSHS's Health and Recovery Services Administration (HRSA) in coordination with other DSHS administrations and other state agencies including the Department of Health, Governor's Office and Health Care Authority.

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

Washington State assures that expenditures for child health assistance will not be claimed prior to the time the State has legislative authority to operate the State plan or before the plan amendment is approved by CMS.

1.3 ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

Washington State assures that the state complies with all applicable civil rights requirements.

1.4 ☒ Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective date for change of certification period from 6 months to 12 months: July 1, 2005

Implementation date: July 1, 2005

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

Based on data from the 1998 Washington State Population Survey (WSPS)[1], 93% of all children in Washington had health insurance coverage in April/May 1998[2]. Approximately 135,000 (93%) of the children with incomes between 200% and 250% of the federal poverty level (FPL) had coverage. About 10,000 children in this income range were without health insurance and are the target population for coverage under Washington's CHIP.

Children's health coverage varied across income levels. Approximately 14% of children in families with incomes up to 200% of FPL did not have health coverage at the time of the 1998 WSPS. These children are eligible for coverage under Washington's current Medicaid program and are being targeted for coverage through several statewide outreach initiatives. In comparison, the uninsured rate for children between 200% and 250% of FPL was 7%, and was less than 4% for children in households above 250% of FPL.

Based on this WSPS data, there is not a significant difference in the overall age/sex composition of families based on income. There were slightly more (32%) younger children (age 0 through 5) in the Medicaid income population compared to the CHIP income population (30%) and higher income families (28%). In part, this may be due to younger families with less income than older families. There appeared to be slightly more female children (54%) in the CHIP income population compared to Medicaid and higher income families (49%). However, the uninsured rates for children were significantly more influenced by income levels than any children's age/sex attributes.

The distribution of children by race varies across income levels. There were proportionately more Black, Native American, and Asian children in the Medicaid income population level than White children. The distribution of CHIP income level children by race was not different than the higher income families, except that proportionately fewer Asian children were in the CHIP income range.

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[1] A list of all abbreviations used in this application is found in Appendix 1.

[2] Washington State has implemented a biennial Washington State Population Survey (WSPS) to provide a profile of residents between decennial censuses. The WSPS is designed to replicate the Bureau of the Census's national Current Population Survey (CPS). However, the WSPS employs a greatly enhanced sample size, which allows for statistically reliable analysis for the state and regions within the state. The health status information reported is household member's status at the time of the interview (April and May 1998).

The source of children's health coverage also varied across income levels. In 1996, 53% of Washington's children in households below 200% of FPL obtained coverage through the state's Medicaid financed programs, 30% had employer-related coverage, and only 3% had individual coverage[3]. Consistent with national trends, employer-based coverage was the principal source of coverage for higher income children. Approximately 84% of children in households above 200% of FPL obtain coverage through their family's employer or union, and 9% had coverage purchased in the individual health insurance market.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Washington currently covers 571,000 children in state subsidized health care programs. This represents 33% of the entire state population of children. Washington has employed four strategies to provide health coverage to its children. These include major Medicaid expansions, implementation of the state subsidized Basic Health Plan, comprehensive health insurance reforms, and Medicaid outreach initiatives.

First, the Washington Department of Social and Health Services (DSHS) has been a national leader in expanding Medicaid coverage to children. In 1989, DSHS implemented its "First Steps Program" to improve birth outcomes. This included expanded Medicaid coverage to pregnant women and infants in households up to 185% of FPL. In 1991, children's health coverage was made available to all children up to age 18 residing in households with income up to 100% of FPL. This program was converted to Medicaid in 1992, and eligibility was expanded to include children up to age 19. In 1994, Medicaid coverage was expanded to 200% of FPL for children through age 18. Prior to the enactment of CHIP in 1997, Washington was one of only four states with Medicaid coverage at or above 200% of FPL.

Second, Washington implemented the Basic Health Plan (BHP) in 1988 to provide state subsidized health coverage to low-income persons. Until Medicaid was expanded to 200% of FPL in 1994, BHP offered subsidized coverage to children and their families up to 200%. Today, there are 56,656 Medicaid covered children whose parents receive subsidized BHP coverage.

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[3] This data is from a Robert Wood Johnson Foundation funded Family Insurance Survey conducted by RAND. The survey over-sampled Medicaid families. However, it was not adjusted for under-reporting of Medicaid.

Third, in 1993, Washington enacted legislation to implement comprehensive health reform. The goal of this legislation was to ensure that all residents had health coverage. Although major portions of the law were repealed in 1995, the state did retain comprehensive insurance reforms on limiting preexisting conditions to three months and requiring health carriers to guarantee portability and reissuance. Non-subsidized BHP coverage was implemented through the Health Care Authority (HCA) to offer group-rated coverage to individuals above 200% FPL. Funding was provided to expand subsidized BHP coverage and to expand children's Medicaid coverage up to 200% of FPL. Currently, BHP is authorized to cover 125,000 people.

As a result of the first three strategies, Washington has a significantly lower uninsured rate for children than most other states. The Urban Institute estimated that Washington's 1994-95 uninsured rate for children below 200% of FPL was 8.1% compared to 14.3% nationally, and that the overall uninsured rate for children was 5.9% compared to 10.4% nationally, and that the overall uninsured rate for children was 5.9% compared to 10.4% for the nation [4].

The fourth strategy in the effort to identify and enroll uncovered children includes several outreach efforts to publicize the availability of coverage. These efforts include: public notifications, such as posters and bus posters; contracting with several of the large county Health Districts to identify potential eligibles and assist them in applying for coverage; and educating Medicaid providers and health care plans.

As part of the current outreach contracting process, HRSA requires contractors to develop and document specific activities for conducting targeted outreach activities to diverse communities at the local (community) level. Specifically, the contractor must describe special efforts to contact and enroll ethnic minorities, non-citizens, immigrants, and homeless individuals. These plans are evaluated and must be approved by HRSA staff. HRSA staff also participate in routine community meetings with outreach contractors and community based representatives to discuss outreach activities. (A description of the Medicaid Client Outreach program is included in Appendix 2).

Each region in the state has a Limited English Proficiency coordinator to help address cultural and communication issues. HRSA also routinely translates client materials into 7 different languages, with 20 languages available for translation if needed. In addition, if there are more than 100 CHIP clients who speak a particular language, HRSA translates into the particular language needed.

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[4] Kaiser Commission on the Future of Medicaid, Child Health Facts (January 1998). The data is from the Urban Institutes TRIM using adjusted March 1995 and 1996 Current Population Survey (CPS) data. TRIM inputs Medicaid enrollment rates to offset under-reporting of Medicaid coverage. As a result, the Urban Institute's uninsured rate estimates are significantly lower than either CPS or WSPS rates for low-income children and adults.

In spite of the aforementioned efforts to offer affordable health coverage to children in households below 200% of FPL, there are still 65,000 children residing in Washington who do not have coverage. There is also growing concern nationally those low-income families who are eligible for Medicaid may not be seeking this coverage due to welfare reform. Many families are unaware that they can continue to receive Medicaid after leaving the Temporary Assistance for Needy Families (TANF) program. In response, DSHS's Health and Recovery Services Administration (HRSA) has begun several initiatives, as described below.

1. Fewer requirements: With the implementation of WorkFirst, HRSA exercised the option not to require families applying for Medicaid to participate in WorkFirst activities such as job search and completion of the individual personal responsibility plan (IPR). There are also no deprivation requirements for TANF-related medical programs. DSHS's Economic Services Administration (ESA) request legislation passed in April 1999, removing deprivation requirements for cash TANF and State Family Assistance (SFA), effective August 1999. CSO staff no longer need to consider deprivation due to absence of a parent, unemployment or work quarters for TANF-related cash or medical benefits.

2. Outreach: HRSA implemented a statewide, community-based Medicaid Client Outreach Project. This project targets pregnant women, children and families. HRSA staff trained outreach contractors about general Medicaid eligibility requirements, the application process, and managed care enrollment.

3. Joint Childcare and Medical Application: HRSA and ESA are developing a joint childcare and children's medical application. A family will only need to complete one application for both childcare and children's medical.

4. Interviews Waived: HRSA has waived the interview requirement for Family (TANF-related) medical. Working families are able to apply for benefits without taking time off from work for an interview.

5. Client Notices: HRSA is working with Employment Security (ES) and ESA to develop post-employment materials. One example is a mailing to all cash TANF clients who become employed, describing medical coverage, including the availability of transitional Medicaid.

6. Training Financial Workers: HRSA eligibility staff trained CSO field staff on TANF-related medical programs during the summer of 1999. This training emphasized the difference between cash TANF and medical coverage. Trainers stressed the need to complete a redetermination when terminating cash TANF.

7. Medical Extensions: When a client is terminated from TANF due to earned income, the Automated Client Eligibility System (ACES) prompts the CSO field staff to provide the client with the earned income 12-month medical extension. In addition, staff are encouraged to use the 3 months retro-eligibility to establish Medicaid coverage in the "last 3 out of 6 months".

8. Continuity of Coverage for Children: ACES has been modified to assure that the children of TANF clients automatically receive medical benefits under Children's Medicaid when a family exits TANF.

9. Educating families about Transitional Medicaid benefits: Staff are reviewing ACES notices to clients to assure they notify clients of coverage they may be able to receive. HRSA will also review WorkFirst materials to ensure adequate/appropriate information about medical eligibility. HRsA staff has trained outreach contractors on these benefits and provides refresher training.

   Other than death, moving out of state and loss of contact, when a worker terminates cash TANF, a family medical status (F04) will be opened for 3 months. The reason for this time frame is that it will put the case in an eligibility review cycle. Either the worker will redetermine eligibility or the client will submit a review.

10. When an application for cash benefits is denied for "no-show interview", there is an edit that will force a determination for medical, since medical has no interview requirement.

11. Reviewing closed TANF cases: HRSA staff are researching whether MMIS can be used to generate a list of clients terminated from TANF and then notify likely eligibles of the programs they may be eligible for.

12. Eliminating auto-denials for medical coverage: Staff are examining options for modifying the auto-denial processes in ACES so more clients may continue receiving medical coverage.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

To assist in making health coverage affordable to low-income persons, the Health Care Authority's (HCA) Basic Health Plan (BHP) has adopted a sponsorship program with public and private entities. These entities, including health care providers – but not health care plans, are allowed to pay all or a portion of the sponsored enrollee's premium obligations (but not co-pays). About 27,000 BHP adults and children are receiving coverage through these sponsorship arrangements.

Employers can also purchase group coverage for themselves and their employees through BHP. Employers must enroll at least 75% of all eligible employees within the classification of employees. BHP may charge a minimum financial contribution for each enrolled employee. Employers are required to offer their employees the complete choice of BHP plans available within the employer's county of residence. About 1,000 adults and children are receiving BHP coverage through their employer.

Although BHP's financial sponsorship and employer coverage options are not specifically targeted to children, they provide affordable health coverage to families. Children in these families are able to receive full-scope Medicaid coverage without cost sharing through the BHP Plus program.[5]

5 This is part of the Health Care Authority's subsidized health care program

Most children are able to receive this coverage through the same health plan and provider network as their family members. About 3,300 Medicaid funded BHP Plus children are connected to a family member receiving sponsorship or employer coverage.

HRSA is coordinating its outreach efforts with BHP and private organizations, including the Seattle Campaign for Kids 2001 and the Washington Campaign for Kids 2001, which is a Robert Wood Johnson Foundation (RWJF) funded outreach project. One noteworthy project has been the Seattle Campaign's coordination with the Seattle School District to identify children eligible for Medicaid. A campaign workgroup has revised the Free & Reduced Lunch application to include a checkbox for the family to apply for Medicaid. In Washington, nearly all children receiving free and reduced lunches are also eligible for Medicaid.

The Department of Health provides funding to the "Healthy Mothers/Healthy Babies" program for a statewide toll-free telephone number. This number provides information on Medicaid and CHIP eligibility for those clients who might qualify for services.

2.3. Describe the procedures the state uses to accomplish coordination of CHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

Washington's CHIP program coordinates with the BHP application process. Currently, Washington's Medicaid program has an interagency agreement with the HCA's BHP to cover children under 19 years of age with family incomes at or below 200% FPL. If a family checks a box on their application that states they would like to apply for BHP Plus for their children, HCA automatically forwards the application to HRSA. This is permissible under the special rule provision of Title XXI, Section 2110(b)(3). HRSA then processes eligibility for Medicaid or CHIP, depending on the program the child is eligible for.

For our Title V Children with Special Health Care Needs (CSHCN) population, we identify clients through both self-identification and a data match with Title V. We coordinate services for our Title V children with representatives from the Department of Health, regional CSHCN representatives, community based groups and organizations, and CSHCN care coordinators. HRSA representatives meet with these groups on a regular basis to discuss and clarify policies, care plans, relevant issues, and complaints. HRSA also has a representative on the Medicaid Integration Team whose purpose is to share information and address issues regarding CSHCN that may come up at the regional level.

We also utilize our outreach contractors to help with identifying potential eligibles and assisting them in applying for all types of benefits.

Our statewide toll-free line helps families apply for all types of benefits and connects them with local resources.

Also, our children's medical applications are available in a broad array of public and community locations, such as physician offices, schools, and community health departments.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

Washington's CHIP utilizes Washington's Medicaid managed care delivery system. This managed care system consists of contracts with health carriers for medical care coverage, contracts with Regional Support Networks (RSN's) for mental health care, and fee-for-service (FFS) for primary care case management (PCCM) clinics. Other Medicaid services are "carved out" of managed care and provided on a "wrap-around" FFS basis. These include dental coverage, chemical dependency services, eyeglasses, hearing aid devices, pregnancy terminations, and non-emergent transportation.

HRSA contracts with health carriers registered with the state's Office of Insurance Commissioner (OIC) to provide full-scope medical coverage on a full-risk capitation basis. This program is called Healthy Options (HO). HRSA currently contracts with seven health carriers that provide medical coverage in 38 of 39 counties in the state (see Appendix 3 for a chart of carriers by county). If HO contracts do not contract for coverage in a given county or a contracting plan's network is not able to provide sufficient access throughout the county, enrollees will be allowed to receive coverage through FFS. As of June 2002, there were 450,004 Medicaid and CHIP clients enrolled in Healthy Options. Of these, 4,369 are CHIP enrollees.

HRSA's HO program also contracts with Indian Health Services (IHS) and tribal operated health clinics to provide PCCM coverage to American Indians/Alaska Natives. As of June 2002, 19 CHIP enrollees have PCCM coverage.

CHIP Enrollees will be required to enroll in managed care arrangements and will receive the same schedule-of-benefits as Medicaid clients. If HO contractors do not contract for coverage in a given county or a contracting plan's network is not able to provide sufficient access throughout the county, enrollees will be allowed to receive coverage through FFS. Given that CHIP enrollment will be less than 3% of the existing HO children's enrollment, there should be sufficient capacity. HRSA will assess if there is sufficient access by comparing a carrier's provider network with state plan networks with respect to the number and geographic distribution of providers across the county.

A CHIP household is not required to select a HO plan for their child as part of the application process. If a client does not voluntarily choose a plan, they will be assigned to a plan when there are two or more plans in their community.

HRSA's Mental Health Division (MHD) contracts with public Regional Support Networks (RSNs) to offer mental health services through prepaid health plan coverage. There are 14 RSNs providing mental health coverage in all 39 counties of the state. All Medicaid and CHIP children are required to enroll in the RSN providing coverage in their county of residence in order to receive mental health care.

In September 1998, the MHD and then-MAA (now HRSA) completed a series of meetings with stakeholders to create a joint mental health policy statement. Included in these meetings were representatives for RSNs, Community Mental Health Centers (CMHC), managed care health plans, mental health client advocates, agency staff, and others. The policy statement recognized that:

1. There is an overlap of benefit coverage between RSNs and the HO managed care plans;

2. There is a strong need for managed care plans and RSNs to coordinate services;

3. Managed care plans, should they authorize accessing a specialty mental health provider, can manage the mental health benefit differently, and

4. HRSA and MHD would expect that if, after a mental health assessment/evaluation has been made, a patient is determined to have a condition requiring him/her to receive more than 12 hours of treatment over 12 months, the patient is immediately referred to the RSN for treatment. In other words, the managed care plan is not responsible for the first 12 hours of treatment if more than 12 hours is needed to stabilize a patient in a given year. Conversely, if the patient is assessed and found to need 12 hours or less of therapy, the managed care plan would be responsible for these services.

HRSA has developed procedures with MHD to assure coordinated care. HRSA sends a monthly tape to MHD identifying Medicaid clients and their eligibility group and CHIP clients.

Substance abuse treatment services are not included in the HO capitation rates and are paid outside the contracts. HO contracts require that licensed health carriers assure that care is coordinated with non-participating community health and social program providers, including substance abuse providers. To have the alcohol and drug treatment paid through the medical assistance program, patients enrolled in HO must receive substance abuse treatment from state certified treatment agencies.

HRSA has developed procedures with the Division of Alcohol and Substance Abuse (DASA) to assure coordinated care. DASA provides services based on clinical need, not insurance coverage. HRSA notifies DASA of those clients covered by CHIP. Assessments to determine the extent of the problem and course of treatment are determined by one of the county-identified outpatient treatment providers. Each county has an Alcohol and Drug Coordinator who administers the drug and alcohol programs for their county.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

HO plans are required to manage service utilization according to standards in the state's Quality Improvement Program Standards. Before being approved for participation in the program, health plans must have in place utilization review infrastructure and protocols for, but not limited to:

- Determination of medical appropriateness and denial of services;
- Referrals to specialty care;
- Clinician participation and use of clinical practice guidelines;
- Twenty-four hour availability of clinical consultation;
- Availability and profiling of practitioners;
- Identification of members with chronic/high-risk illnesses, hospital discharge planning, case management, and coordination of special needs;
- Access and timeliness of services; and
- Review of under or over utilization of care.

Internal monitoring reviews will be routinely conducted to assure that medically necessary care is delivered in a cost-effective and efficient manner. External quality reviews, in accordance with federal law (Section 1902 (a) (30) (C) of the Social Security Act), will be conducted annually for selected services by all managed care organizations (MCO's) contracted with the program.

Utilization controls for CHIP children on FFS coverage are consistent with all utilization review requirements of Title XIX. Examples of utilization controls include external review of hospital claims data, exception-to-policy procedures, data audits, pre-authorization for extended coverage utilization, and drug utilization review.

Refer to Section 7 – Quality and Appropriateness of Care – for more information on utilization control.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. ☒ Geographic area served by the Plan: The entire state of Washington.
4.1.2. ☒ Age: Children under the age of nineteen.
4.1.3. ☒ Income: Above 200% FPL up to and including 250% FPL.
4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources): There is no resource test.
4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state): A Washington resident who intends to continue living here, or who entered the state looking for a job or entered the state with a job commitment (WAC 388-468-0005).
4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility): There is no disability status requirement.
4.1.7. ☒ Access to or coverage under other health coverage: CHIP coverage is not available to children who are otherwise eligible for Medicaid or who have "creditable coverage".
4.1.8. ☒ Duration of eligibility: **Twelve months**.
4.1.9. ☐ Other standards (identify and describe): None.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

HRSA uses two standardized application forms to make eligibility determinations. One form is used for clients applying for the Medicaid children's medical program (a one-page form). The other form is used for clients applying for cash benefits, food stamps, medical coverage and other benefits. Potential CHIP eligibles can apply for medical coverage by using either form.

Information from the application is entered into the state's ACES, which automatically generates CHIP eligibility notices and reviews. ACES transfers eligibility information to the Medical Management Information System (MMIS). MMIS information is used to enroll clients into managed care.

The application asks the citizenship status of only those children who are seeking benefits. Since disclosure of the Social Security Number is optional, children are enrolled into CHIP without having a Social Security Number.

For continuing enrollment, an eligibility review form is generated and mailed to the head of household approximately six weeks prior to the end of the client's **12 month** certification period. The eligibility review form must be completed with current information such as household members, income, and health insurance status, and returned to state office. The eligibility review form is reviewed first for Medicaid eligibility, then reviewed for CHIP eligibility if they are not Medicaid eligible.

CHIP applicants have the same appeal rights as Medicaid applicants. Applicants who are denied eligibility are sent a letter with information on their rights for a Fair Hearing. Clients may call the Office of Administrative Hearings (OAH) to set up a hearing. OAH notifies the client and the agency's Fair Hearing Coordinator. The Coordinator prepares the case and sets up a pre-hearing conference as a way to settle the dispute or collect information. Cases that are not resolved in the pre-hearing conference proceed to a Fair Hearing. At the Fair Hearing, an Administrative Law Judge gathers information from the client and agency staff. Hearings can be conducted via telephone or in person. The Judge's decision is mailed to the client and the Coordinator. Either party may appeal the decision for additional review and if need be to the courts.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

☒ Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))**

At the time of application and redetermination, eligibility staff first determines whether an applicant or client is eligible for Medicaid. If they are not Medicaid eligible, staff assesses eligibility for CHIP and enrolls them in CHIP, if appropriate. To assist in this process, eligibility staff utilizes ACES automated protocols. Also, there is a series of required questions on the application and eligibility review form that ask about the child's health insurance status. If these questions are not answered at the time of application or review, the applicant is sent an "Insurance Information Request" letter, which must be completed before eligibility can be determined.

We also check our MMIS system both at the time of application and redetermination to see if there is any history of a third party insurance showing for the household that needs to be researched. In addition, our Coordination of Benefits section reviews a monthly report of currently eligible CHIP clients to see whether any clients have health insurance coverage.

The following individuals are ineligible for CHIP: Anyone who at the time of application or redetermination is covered under a group health plan or health insurance coverage; has access to, or coverage under, a state health benefits plan; or who is Medicaid eligible.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

All applications are first reviewed for Medicaid eligibility, and applicants are enrolled in Medicaid if found eligible. This process is automated through ACES automated protocols. Eligibility for CHIP is determined only after eligibility for Medicaid is reviewed and determined.

4.4.3. The State is taking steps to assist in the enrollment in CHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

The ACES eligibility system automatically prompts for Medicaid eligibility prior to consideration of eligibility for CHIP. After Medicaid eligibility is determined, ACES automatically prompts for CHIP eligibility based on the applicant's income level.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. ☐ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

The State ensures that substitution of coverage does not occur in several ways. First, both the application and the eligibility review form ask a series of questions regarding health insurance status of the applicant's children. If they respond affirmatively to any of these questions, we ask the applicant to list the name of the insurance company or employer providing the insurance. The following individuals are ineligible for CHIP: Anyone who at the time of application or redetermination is covered under a group health plan or health insurance coverage; has access to, or coverage under, a state health benefits plan; or who is Medicaid eligible.

If the client does not respond to the questions, they are sent an "Insurance Information Request" letter that the applicant must respond to in order for CHIP eligibility to be determined. If the client has access to health insurance coverage, they are not enrolled in CHIP.

Also, at the time of application and redetermination the MMIS is checked to see if there is any history showing of insurance coverage for the household. If a history shows, further inquiries can be made.

To monitor substitution of coverage, the State tracks responses on the number of applications and eligibility reviews that show the applicant has insurance coverage. In addition, the State tracks the number of applications and eligibility reviews that are denied due to insurance coverage.

Additionally, the State tracks whether the applicant has disenrolled from employer sponsored coverage. If the applicant has lost employer sponsored insurance coverage within the past 4 months, the child must serve a four-month waiting period. However, prior to imposing a waiting period, we look at whether one of nine exceptions applies to the family's situation. Exceptions to the four-month waiting period may be granted when:

1) Parent lost job that has medical coverage for children.
2) Parent with medical insurance died.
3) Child has a medical condition that, without medical care, would cause serious disability, loss of function or death.
4) Employer ended medical coverage for children.
5) Child's medical coverage ended because the child reached the maximum lifetime coverage amount.
6) Coverage under a COBRA extension period ended.
7) Children could not get medical services locally (they have to travel to another city or state to get care for their children).
8) Domestic violence led to loss of coverage.
9) The family's total out-of-pocket maximum for employer-sponsored dependent coverage is fifty dollars per month or more.

If none of the exceptions apply, the child must serve a 4-month waiting period prior to enrollment in CHIP.

Another way we monitor for substitution of coverage is through the review of a monthly report of currently eligible CHIP clients. HRSA researches this report for health insurance coverage to ensure there was no substitution of coverage at the time of application or redetermination.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Targeted low-income children who are American Indian or Alaska Native (AI/AN) will be subject to the same eligibility criteria as other low-income children. HRSA has coordinated with and will continue to work with representatives of the Tribes in the state of Washington, urban Indian organizations, and Indian advocacy groups, including the Northwest Portland Area Indian Health Board, the American Indian Health Commission, and the DSHS Indian Policy Advisory Committee, to develop outreach programs and methods that specifically target AI/AN children. CHIP has been, and will continue to be a regular agenda item at meetings with these groups.

CHIP policy will mirror HRSA Medicaid enrollment policy for AI/AN children. AI/AN clients are not required to enroll in HO plans. Instead, AI/AN children may choose a managed care plan, an Indian clinic operating as a primary care case manager (PCCM), or fee-for-service.

ADDENDUM TO SECTION 4.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM
STATE PLAN TEMPLATE

Section 4. Eligibility Standards and Methodology (section 2101(b))

4.1.3. Income:

X All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

The following information on outreach is based on the Medicaid outreach project and the Healthy Kids Now (HKN) public information campaign. Both of these activities target Medicaid and CHIP children. Children must be assessed for Medicaid eligibility as a condition of determining CHIP eligibility.

Background

In 1998, the Washington State Legislature authorized HRSA to spend up to $3.9 million in enhanced funds for outreach to Medicaid eligibles. This project began in October 1998 and ended in June 2001. In July 2001, we began using CHIP funding to support new outreach contracts. This funding will end in September 2002. The HKN campaign began in February 2000, when CHIP was launched in the State, and continues to support Medicaid and CHIP outreach efforts through statewide activities, facilitating community efforts, and the statewide toll-free line, 1-877-KIDS-NOW.

Contracts

The state of Washington continued its support of the HKN public information campaign as well as community-based organizations by contracting with 35 organizations, covering 36 of our 39 counties. Contractors include health districts, county social service departments and eight Indian tribes. We required contractors to submit applications that had to be approved before proceeding. After signing contracts, we provided local training to project staff on outreach strategies, eligibility criteria, and enrollment process. The State reimbursed contractors by paying a monthly set rate and paying a $20 incentive for each client a contractor helps enroll. The community contracts were scheduled to end March 31, 2000, when the authorizing federal legislation sunsetted. However, in November 1999, Congress lifted the sunset date, so we were able to extend the outreach contracts until June 30, 2001, or until the enhanced federal funds were spent.

With the depletion in June 2001 of the $3.9 million in enhanced federal matching funds, contractors needed to come up with a higher match rate in order to contract for the available CHIP outreach dollars beginning in July 2001. We now have 25 contracts that cover 33 of Washington's counties. Counties that do not have an outreach contractor can call the HKN toll-free line or their local Community Services Office (CSO) for assistance.

Community-based contractors are required to:

- Identify people likely to be eligible for coverage;
- Account for federal outreach funds in accordance with federal requirements;
- Educate potential eligibles on the benefits of participating in the Medicaid/CHIP program and eligibility requirements;
- Assist potential eligibles with completing an application for eligibility;
- Educate new clients on how to access services, and
- Assist new clients with selecting a Healthy Options health care plan that will best meet their needs.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

- 6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)
- 6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☒ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☒ Coverage the same as Medicaid State plan

Washington's CHIP will provide the same scope of coverage as provided under its Medicaid program. The chart below lists the medically necessary services available to children eligible for Categorically Needy (CN) Medicaid under Title XIX of the Social Security Act (SSA) and CHIP under Title XXI of the SSA.

- 6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- 6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit-by-benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

SERVICE	MEDICAID CN	CHIP
Advanced RN Practitioner Services	Yes	Yes
Ambulance/Ground and Air	Yes	Yes
Anesthesia Services	Yes	Yes
Audiology	Yes	Yes
Blood/Blood Administration	Yes	Yes
Case Management – Maternity	L	L
Chiropractic Care	Yes	Yes
Clinic Services	Yes	Yes
Community Mental Health Centers	Yes	Yes
Dental Services	Yes	Yes
Dentures Only	Yes	Yes
Detox (3 days)	Yes	Yes
Drugs and Pharmaceutical Supplies	Yes	Yes
Elective Surgery	Yes	Yes
Emergency Room Services	Yes	Yes
Emergency Surgery	Yes	Yes
Eyeglasses and Exams	Yes	Yes
Family Planning Services	Yes	Yes
Healthy Kids (EPSDT)	Yes	Yes
Hearing Aid	Yes	Yes
Hospice	Yes	Yes
Home Health Services	Yes	Yes
Indian Health Clinics	Yes	Yes
Inpatient Hospital Care	Yes	Yes
Intermediate Care Facility/Services for MR	Yes	Yes
Involuntary Commitment	Yes	Yes
Maternity Support Services	Yes	Yes
Medical Equipment, Durable (DME)	Yes	Yes
Midwife Services	Yes	Yes
Neuromuscular Centers	Yes	Yes
Nursing Facility Services	Yes	Yes
Nutrition Therapy	Yes	Yes
Optometry	Yes	Yes
Organ Transplants	Yes	Yes
Out-of-State Care	Yes	Yes
Outpatient Hospital Care	Yes	Yes
Oxygen/Respiratory Therapy	Yes	Yes
Pain Management (Chronic)	Yes	Yes
Personal Care Services	Yes	Yes
Physical/Occupational/Speech Therapy	Yes	Yes
Physical Medicine and Rehabilitation	Yes	Yes
Physician	Yes	Yes
Podiatry	Yes	Yes
Private Duty Nursing	L	L
Prosthetic Devices/Mobility Aids	Yes	Yes
Psychiatric Services	Yes	Yes
Psychological Evaluation	L	L

Rural Health Services & FQHC	Yes	Yes
Substance Abuse/Outpatient	Yes	Yes
Surgical Appliances	Yes	Yes
Total Enteral/Parenteral Nutrition	Yes	Yes
Transportation Other than Ambulance	Yes	Yes
X-Ray and Lab Services	Yes	Yes

Key:
Yes: Service is covered (may require prior approval or have other requirements)
L: Limited coverage

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

6.2.1. ☒ Inpatient services **(Section 2110(a)(1))**
6.2.2. ☒ Outpatient services **(Section 2110(a)(2))**
6.2.3. ☒ Physician services **(Section 2110(a)(3))**
6.2.4. ☒ Surgical services **(Section 2110(a)(4))**
6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**
6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**
6.2.7. ☒ Over-the-counter medications **(Section 2110(a)(7))**
6.2.8. ☒ Laboratory and radiological services **(Section 2110(a)(8))**
6.2.9. ☒ Pre-natal care and pre-pregnancy family services and supplies **(Section 2110(a)(9))**
6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**
6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**
6.2.12. ☒ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**
6.2.13. ☒ Disposable medical supplies **(Section 2110(a)(13))**
6.2.14. ☒ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**
6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**
6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**
6.2.17. ☒ Dental services **(Section 2110(a)(17))**
6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**
6.2.19. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**
6.2.20. ☒ Case management services **(Section 2110(a)(20))**
6.2.21. ☒ Care coordination services **(Section 2110(a)(21))**
6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**
6.2.23. ☒ Hospice care **(Section 2110(a)(23))**

6.2.24.☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

6.2.25.☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26.☒ Medical transportation **(Section 2110(a)(26))**

6.2.27.☒ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28.☐ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☒ he state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system**. **The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above. **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR457.1010(c))**

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (**2102(a)(7)(A)) (42CFR 457.495(a))**

The quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and age appropriate immunizations provided under the plan, are addressed for managed care coverage through contract requirements for participating Managed Care Organization (MCOs). Requirements and monitoring criteria are the same as those for the current HO and the fee-for-service (FFS) programs.

The state contracts only with MCOs that are regulated by the Office of the Insurance Commissioner (OIC), which regulates and monitors financial solvency and other consumer protection safeguards.

HRSA monitors the quality and appropriateness of care through:

- Monitoring and analysis of quality standards and performance measures for well-baby care, well-child care, and immunizations required through encounter data, chart review, HEDIS reporting, and a variety of other contract monitoring activities listed below;
- Client interviews;
- Annual client satisfaction/health status surveys for both managed care and FFS clients;
- Complaint management system;
- Exemption/disenrollment/fair hearing database;
- Standards for health plan internal quality improvement programs;
- Network adequacy standards; and
- On-site contract compliance monitoring and technical assistance.

Contract monitoring is performed through the following actions:

- Requiring the same encounter data reporting (form, format, periodicity) as required under Medicaid HO;
- Generating HEDIS reporting and the above mentioned quality measures with the same criteria as Medicaid HO and similar FFS review;

- Applying utilization controls for FFS coverage that are consistent with all current utilization review requirements under the state's Medicaid plan. Examples of controls include external review of hospital claims data, exception-to-policy
-
- Procedures, data audits, pre-authorization for extended coverage utilization, and drug utilization review;

- Performing routine on-site quality and operational reviews of the MCO contractors;

- Reviewing of the MCOs by an External Quality Review Organization (EQRO), as required by federal law (Section 1902 (a) (30) (C) of the Social Security Act);

- Requiring that MCOs maintain an internal program of quality assurance, as required by federal regulations (42 CFR 434.34);

- Performing annual client satisfaction surveys;

- Monitoring of complaints and grievances at both the health plan level and the Medicaid state agency level.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards

In addition to the utilization controls described in Section 3.2, National Committee for Quality Assurance (NCQA) standards are the guidelines for contract requirements and monitoring. Generally, the NCQA standards address the following:

- Quality Management and Improvement – program structure, program operations, health services contracting, availability of practitioners;

- Accessibility of services, member satisfaction, health management systems, primary care provider role, scope and content of clinical quality improvement (QI) activities, clinical measurement activities, effectiveness of the QI program, and delegation of QI activity;

- Utilization Management;

- Credentialing and Recredentialing;

- Members' Rights and Responsibilities; and

- Preventative Health Services and Medical Records.

Quality standards for FFS will be consistent with all quality utilization review requirements under the state's Medicaid plan, and the additional quality activities listed in Section 7.1.

7.1.2. ☒ Performance measurement

Health Plan Employer Data and Information Set (HEDIS) performance measures will be reported and preventive health services relevant to the program such as EPSDT and child immunizations will be evaluated with the same criteria as the current HO program and similar FFS review. See further performance criteria in Section 7.1.4.

7.1.3. ☒ Information strategies

Encounter data, HEDIS measures, provider network adequacy standards, and health care experience data will be reported by health plans. The current complaint management system will be maintained at both the health plan level and the State level to assure timely resolution of client complaints and grievances. FFS information strategies will be consistent with all information requirements under the state's Medicaid plan.

7.1.4. ☒ Quality improvement strategies

The following strategies and activities have been implemented and are consistent with the HO and FFS programs:

- Monitoring and analysis of quality standards and performance measures for well-baby care, well-child care, and immunizations required through encounter data, chart review, HEDIS reporting, and a variety of other contract monitoring activities listed below;
- Client interviews;
- Annual client satisfaction/health status surveys for both managed care and FFS clients;
- Complaint management system;
- Exemption/disenrollment/fair hearing database;
- Standards for health plan internal quality improvement programs;
- Network adequacy standards; and
- On-site contract compliance monitoring and technical assistance.

7.2. Describe the methods used, including monitoring, to assure: (**2102(a)(7)(B)) (42CFR 457.495)**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

7.2.2

The methods used to assure access to covered services, including well-baby care, well-child care, well-adolescent care, and childhood and adolescent immunizations, are based on the Healthy Options program. The methods, including monitoring, will be the following:

Availability of Practitioners

MCOs must have a written access plan describing the mechanisms used to assure the availability of primary care providers (PCPs) and physician specialists, hospitals, and pharmacies. Standards for the number and geographic distribution of PCPs and specialty care practitioners are established in the procurement requirements. MCOs submit their provider networks to HRSA. MCOs must collect and analyze data to measure performance against these standards and implement corrective action when necessary.

As part of the procurement process, HO bidders are required to submit GeoNetwork analysis that describes how its network compares to HRSA/HCA access guidelines for distribution (travel distance) and capacity of primary care providers (PCPs), obstetrical providers, hospitals and pharmacies. This information is compared to BHP and Public Employee Benefit Board (PEBB) networks to judge whether there is sufficient capacity. HO, BHP and PEBB plans are required to submit monthly updates of provider network changes. HRSA and HCA have an Integrated Provider Network Database (IPND) that allows the two agencies to conduct ongoing GeoNetwork analysis to ensure there continues to be an adequate network during the contract period, and to assess whether there is a significant turnover of participating providers.

Accessibility of Services

- Covered services for managed care enrollees, such as types of practitioners and providers, location of practitioners and providers, and timeliness, must be made at least as accessible as for members enrolled under the MCO's other state, federal, or private contracts.

- Coverage for medical advice through a toll-free telephone number on a 24 hour per day, 7 day per week basis must be made available to members for the purpose of rendering medical advice concerning the emergent, urgent or routine nature of a medical condition, and authorizing care at other facilities when the use of participating facilities is not practical. This advice and authorization must be made by a licensed health care professional.

- Mechanisms must be established to assure the accessibility of primary care services, urgent care services and member services.

- Standards (which apply to HO, BHP, PEBB and CHIP) must be established that are no longer than the following:
    - Non-symptomatic (i.e., preventive care) office visit – within 30 calendar days;
    - Non-urgent, symptomatic (i.e., routine care) office visit – within 7 days;
    - Urgent, symptomatic (i.e., presentation of medical conditions requiring immediate attention, not life-threatening) office visit within 24 hours, and
    - Emergency medical care within 24 hours per day, seven days per week.

MCOs must collect and analyze data to measure their performance against the above standards. FFS quality standards and utilization controls are consistent with all quality and utilization review requirements under the state's Medicaid plan.

7.2.3 Access to covered services, including emergency services as defined in 42 CFR 457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

Please see response to Section 7.2.1 regarding access to covered services. The same criteria apply to all covered services.

For emergency services, the definition of emergency in the plan will be based on the current definition addressing need as defined by the "prudent layperson". As noted above, standards assuring access and network adequacy must be written by MCOs specifying how to access emergency medical care within 24 hours per day, 7 days per week. In addition, emergency care services for medical emergencies must be provided in non-participating facilities when a member:

- Has a medical emergency meeting the contract definition and is not able to use a participating hospital (42 CFR 434.30), or
- Presents at a non-participating hospital emergency department and the member's condition is determined to be non-emergent. In such instances, the MCO must cover facility and professional services for medical screening examinations as defined in the contract.

7.2.4 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

Our contract with MCOs requires the MCO to provide all medically necessary specialty care for enrollees. If an enrollee needs specialty care from a specialist who is not available within the MCO's provider network, the MCO must provide the necessary services with a qualified specialist outside of the MCO's provider network.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

Washington follows Washington Administrative Code 388-501-0165 related to the prior authorization of services.

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 9.

8.1. Is cost sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☒ YES, except for American Indians/Alaska Natives, who are exempt from this requirement.

8.1.2. ☐ NO**, skip to question 8.8.**

8.2. Describe the amount of cost sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

Households are required to pay a $15 per month premium for each child enrolled in CHIP, with a family maximum of $45 per month. Payments can be made for periods greater than one month. Eligibility will end if premiums are not paid for three consecutive months.

Households with enrolled children will receive monthly billing statements. These monthly statements include the current amount as well as any overdue amount. The statement includes a note that accounts over 90 days past due may result in loss of medical coverage. A phone number is provided with a note to call if their income goes down, a family member moves in or out of their home, or a child under age 19 becomes pregnant or disabled, as their children may be eligible for a medical program with no premiums. There is also an additional warning on the statement of clients who are 30 or 60 days overdue.

If a child is terminated from CHIP for failure to pay premiums for four consecutive months, the household receives a letter outlining their rights and responsibilities. The letter says they will not be able to re-enroll for four months and must pay all delinquent premium payments.

8.2.2. Deductibles:
None.

8.2.3. Coinsurance or co-payments:
None.

8.2.4. Other:
None.

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

State-published CHIP brochures and summary documents contain information about enrollee cost-sharing requirements. The CHIP application packet includes detailed information about cost-sharing requirements. CHIP enrollment and health plan enrollment documents also include all cost-sharing requirements.

If there is a change to cost-sharing requirements, we send each client a letter detailing the changes. We provide them with a toll-free number to call if they have any questions about the changes. We also relay this information to the public through our outreach workers, advocates, and notification to providers.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. ☒ Cost sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ☒ No cost sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 ☒ No additional cost sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

With our only cost-sharing requirement being premium payments of $15 per child per month and with a family maximum of $45 per month, households will not be able to exceed 1.2% of a family's income.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

American Indian and Alaska Native children are self-identified at the time of application. This information is put into our MMIS, which codes them appropriately so that no premium billing statement is sent to the household for those children.

If a child is not self-identified at the time of application, our client materials as well as our billing invoice provide information on excluding AI/AN children from the cost-sharing requirement. If premiums were inadvertently paid for an AI or AN child, a refund is issued.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, co-payments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**

Clients are not disenrolled for non-payment of premiums until they have missed four consecutive months of payment. Once an enrollee has missed 90 days of payment, they are sent a letter that informs them that a balance over 90 days may result in loss of coverage. The letter gives them a toll-free number to call to make payment arrangements or to report a change in circumstances that may make them eligible for Medicaid.

☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. **(42CFR 457.570(b))**

Prior to disenrollment, clients are notified in a letter that they can call a toll-free number to report any changes in income or household. This allows their eligibility to be determined for Medicaid or any programs for which they may be eligible.

☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**

Once the eligibility section is notified of a change in income, they will automatically review eligibility for Medicaid.

☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

Enrollees are sent a letter informing them of disenrollment from CHIP. The letter contains information on their rights for a Fair Hearing. Clients can call the Office of Administrative Hearings (OAH) to set up a hearing. OAH notifies the client and the agency's Fair Hearing Coordinator. The Coordinator prepares the case and sets up a pre-hearing conference as a way to settle the dispute or collect information. Cases that are not resolved in the pre-hearing conference proceed to a Fair Hearing. The Administrative Law Judge conducts the hearing. The Judge's decision is mailed to the client and the Coordinator. Either party may appeal the decision for additional review and to the courts if need be.

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☒ No cost sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
(Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

Washington's CHIP strategic objective is to increase the number of children in households between 200% and 250% of FPL who have health insurance coverage. In addition, CHIP will assist the Medicaid program to increase the number of low-income children in households below 200% of FPL who have health insurance coverage.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

The following performance goals have been identified:

1. Increase the number of children between 200% and 250% of FPL who have health care coverage.
2. Reduce the percentage of uninsured children between 200% and 250% FPL.
3. Increase the number of children below 200% of FPL who have health coverage.
4. Reduce the percentage of uninsured children below 200% of FPL.
5. Track the satisfaction and health care of CHIP children compared to Medicaid children and non-Medicaid children.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: **(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))**

HRSA and the Governor's Office of Financial Management (OFM) Forecast Section will analyze WSPS data to measure the number and percentage of children who are uninsured. The WSPS is a comprehensive survey conducted under contract with Washington State University's Social and Economic Sciences Research Center. The survey is modeled after U.S. Bureau of the Census's Current Population Survey (CPS). However, the survey is a statewide survey with a greatly enhanced sample size (6,950 households in 1998) to allow for statistically reliable analyses for the state and regions within the state. There are expanded samples of racial and ethnic minorities to be able to compare socio-economic characteristics of people of different racial and ethnic backgrounds. The WSPS is conducted biennially. Therefore, the CHIP uninsured performance measures will be reported every two years.

The assessment of CHIP enrollees' satisfaction with their health care and services is based on HRSA's work with the Consumer Assessment of Health Plans (CAHPS). HRSA is now incorporating CHIP into the CAHPS surveys. These surveys are conducted in accordance with CAHPS Consortium (A group of national survey experts associated with the Harvard Medical School, RAND, and the Research Triangle Institute protocols. HRSA's 1997 Medicaid survey measured clients' satisfaction with the health care and services received through the Medicaid Healthy Options (HO) program. The 1998 survey included both HO enrollees and Medicaid FFS clients. The 2000 survey included both Medicaid and CHIP

clients. The sampling size for CHIP was very small in 2000 as this was the year CHIP was implemented. A 2001 CAHPS survey was conducted and will be analyzed.

HRSA has been utilizing HEDIS and EPSDT related measures to assess the effectiveness of its HO contractors to provide medically appropriate services to Medicaid clients since 1996. Similar measures are now being applied to Medicaid FFS clients. HRSA contracts with its external review organization to generate a set of similar, child appropriate measures for CHIP enrollees.

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☐ The increase in the percentage of children with a usual source of care.
9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.
9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. ☒ Immunizations
- 9.3.7.2. ☒ Well-child care
- 9.3.7.3. ☒ Adolescent well visits
- 9.3.7.4. ☒ Satisfaction with care
- 9.3.7.5. ☐ Mental health
- 9.3.7.6. ☐ Dental care
- 9.3.7.7. ☒ Other, please list: HRSA will assess whether there is a sufficient number of CHIP enrollees who give birth while on CHIP to warrant tracking birth outcomes through the DSHS First Steps Database. HRSA will also track and compare CHIP dental access and utilization with Medicaid children.

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

Washington State will report on the number of CHIP enrolled children on an annual basis. The number and percentage of uninsured children between 200% and 250% FPL will be reported on a biennial basis using WSPS data.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

Over the past several years of expanding services to children, Washington State has relied on several strategies to assure high levels of community involvement:

- The public had an opportunity to testify on the Governor's proposed CHIP during both the 1998 and 1999 legislative sessions. The public also had an opportunity to comment on an alternative CHIP program that was being offered by House Republicans. Stakeholders and advocacy groups met throughout the 1999 session to comment on and ask legislators to pass the Governor's proposal, which was enacted on a bipartisan basis during the 1999 session.

- HRSA also worked with the Seattle Campaign for Kids 2001 and a potential CHIP demonstration project prior to the 1999 session. Input in that project was reflected in the Governor's proposal and HRSA's CHIP operational design.

- During the development of the CHIP state plan, HRSA involved representatives of various stakeholder groups including the state medical association, the state hospital association, provider groups, representatives of the Legislature, health care plans, client rights organizations and client advocacy groups. The public meetings held to review the plan submittal were jointly sponsored by HRSA and the Children's Alliance – a statewide children's advocacy group.

- HRSA sponsors fourteen local community groups to provide feedback on the Healthy Options program. The Healthy Options Committees were asked to provide input, as well as feedback throughout implementation.

- HRSA consulted with the American Indian Health Commission of Washington State and the Northwest Portland Area Indian Health Board on the design of CHIP. CHIP had been an item of discussion for over a year with these groups.

- HRSA also provided an opportunity for all interested parties to review and comment

on the original State Plan application through HRSA's CHIP website. [7]

The combination of statewide and local input provided a robust mechanism for assuring broad input into the planning and implementation stages of CHIP.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. **(Section 2107(c)) (42CFR 457.120(c))**

HRSA consulted with the American Indian Health commission of Washington State and the Northwest Portland Area Indian Health Board on the design of CHIP. HRSA has coordinated with and will continue to work with representatives of the Tribes in the state of Washington, urban Indian organizations, and Indian advocacy groups, including the Northwest Portland Area Indian Health Board, the American Indian Health Commission, and the DSHS Indian Policy Advisory Committee. Although the total number of Indian children to be served by CHIP is expected to be small (approximately 300), the increased commitment by the State to Indian health issues is viewed by the Tribes as an important move.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

The proposed rule to accommodate the change to 12 month eligibility was filed on August 3, 2005, with a public hearing on Sept. 6, 2005. The rule became effective on October 13, 2005. The proposed rule to accommodate the requirement for a Social Security number was filed on Sept. 6, 2005, with a public hearing on Oct. 11, 2005. The rule became effective on Jan. 1, 2006.

7 http://maa.dshs.wa.gov/CHIP/Index.html

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.

- Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

Enhanced FMAP Rate	**Federal Fiscal Year 2005 Costs**	**Federal Fiscal Year 2006 Costs**
	65%	**65%**
Benefit Costs		
Insurance Payments		
Managed Care	$ 14,540,155	$ 15,055,631
Per member/per month rate @ # of eligibles	128	133
Fee-for-service	2,427,700	2,934,056
Total Benefit Costs	**16,967,855**	**17,989,687**
(offsetting beneficiary cost sharing payments)	(1,458,666)	(1,257,205)
Net Benefit Costs	**15,509,189**	**16,732,482**
Administration Costs		
Personnel (A/B)	$ 365,983	$ 394,850
General Administration (E/G/J/S/T less ER)	111,713	120,524
Contractors/Brokers (e.g.,enrollment contractors)(C/ER)	263,335	284,105
Claims Processing (H6656 &H9656)	35,176	37,950
Outreach/marketing costs (N) (C51D5)	102,398	110,475
Other [500]		
Total Administration Costs	**878,6040**	**947,904**
10% Administration Cost Ceiling	1,723,243	1,859,165
Federal Share (multiplied by enh-FMAP rate)	10,652,065	11,492,251
State Share	5,735,727	6,188,135
TOTAL PROGRAM COSTS	**16,387,793**	**17,680,385**

*The Health Services Account is used for maintaining and expanding health services access for low-income residents, maintaining and expanding the public health system, maintaining and improving the capacity of the health care system, containing health care costs, and the regulation, planning and administering of the health care system. This account is funded from B&O Hospital tax, cigarette tax, tobacco products, liquor liter and excise tax, beer taxes, HMO premiums, tobacco settlement payments and the DSH/ProShare programs.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. **Program Integrity (Section 2101(a))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue to Section 12.

11.1 ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

All CHIP clients have an opportunity for review of eligibility and enrollment matters. Clients may contact MEDS or the Office of Administrative Hearings (OAH) to begin the review process. The HRSA Fair Hearing Coordinator is notified of the request for review. The Coordinator prepares the case and sets up a pre-hearing conference as a way to settle the dispute or collect information. Cases that are not resolved through a pre-hearing conference proceed to a Fair Hearing. At the Fair Hearing, an Administrative Law Judge gathers information from the client and agency staff. Hearings can be conducted via telephone or in person. The Judge's decision is mailed to the client and the Coordinator. Either party may appeal the decision for additional review and to the courts if need be.

Health Services Matters

12.2 Please describe the review process for **health services matters** that comply with 42 CFR 457.1120.

All CHIP clients also have an opportunity for review of health services matters. The process as described in section 12.1 is the same process used for review of health services matters.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Not applicable to Washington State's CHIP.